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FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Madagascar

SUMMARY

The Executive Director recommends that the Executive Board approve:

(a) The country programme of Madagascar for the period 1996 to 2000 in the amount of $15,900,000 from general resources, subject to the availability of funds, and $44,100,000 in supplementary funds, subject to the availability of specific-purpose contributions;

(b) Additional general resources in the amount of $165,000 to fund the approved country programme for the period 1990 to 1995 for which the balance of approved general resources is not sufficient to fund the programme up to the approved programme period.

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*In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1994, will be contained in the "Summary of 1995 recommendations for general resources and supplementary funding programmes" (E/ICEF/1995/P/L.10 and Add.1)

THE SITUATION OF CHILDREN AND WOMEN

1. With a per capita gross national product of $230, the people of Madagascar are 50 per cent poorer today than 20 years ago. Forty-seven per cent of the 13.3 million inhabitants live in poverty.

2. The growth of the economy has averaged 2.2 per cent a year for the last 20 years and is less than the population growth rate of 2.7 per cent. The country's development is seriously compromised by an official debt burden of over $4 billion and debt servicing represents, on average, 80 per cent of export earnings. The following structural adjustment measures have been adopted: floating of the Malagasy currency, which is equivalent to a devaluation of 75 per cent; privatization; withdrawal of the State from production activities; and the gradual liberalization of markets. Such measures have caused significant price increases for basic goods and the deterioration of basic services.

3. The government policy of free access to health and education services resulted in significant improvement in coverage, with 2,500 health centres and more than 11,000 public primary schools. Higher coverages, in turn, brought about slight decreases in the infant mortality rate (IMR) and the under-five mortality rate (U5MR) during the 1980s and the achievement of universal access to primary education. However, cuts in social sector budgets due to structural adjustment measures in the late 1980s have eroded the system of public social services in the 1990s.

4. In 1993, IMR and U5MR were 100 and 164 per 1,000 live births, respectively, the same as in 1990. These rates are worse in rural than in urban areas. The maternal mortality rate (MMR) was 570 per 100,000 live births in 1988. The nutritional status of Malagasy children and women is precarious. The rate of moderately and severely underweight children under the age of five years has increased between 1984 and 1992 from 33 to 39 per cent. The main causes of child mortality are malaria, acute respiratory infections (ARI) and diarrhoea, which together account for nearly 60 per cent of U5MR. With an oral rehydration therapy (ORT) usage rate of only 29 per cent, diarrhoea remains a major cause of under-five mortality. The increase in child immunization coverage since 1981 has reduced the incidence of expanded programme on immunization (EPI) diseases. Even with immunization coverage of only 52 per cent, measles no longer appears to be a major cause of infant mortality and morbidity. In 1994, 19 suspected cases of poliomyelitis were detected, as compared to 40 in 1990. However, there has been a reduction in the number of pregnant women immunized against tetanus from 60 per cent in 1990 to 16 per cent in 1993. The major immediate causes of maternal mortality are complications of pregnancy and delivery, including abortion and post-partum haemorrhages. The underlying factors are early and short-spaced pregnancies due to insufficient family planning and the inability of the health system to prevent and detect complications of pregnancy and delivery. There have been 45 cases of persons who have tested positive for the human immunodeficiency virus (HIV), of which 4 are full-blown cases of acquired immune deficiency syndrome (AIDS). With a reported prevalence of sexually transmitted diseases (STDs) as high as 30 per cent among pregnant women and the inadequacy of blood transfusion safety measures, there is a potential risk of expansion of the HIV epidemic.

5. Poor utilization of health services is one significant reason for the poor health status of children and women. Although 65 per cent of the population live within five kilometres of a health centre, only 30 per cent of health centres are actually functional. The lack of drugs, dilapidated infrastructure, high service costs, poor management and limited motivation and competence of the health personnel contribute to a substandard quality of services. Most of these factors are due to insufficient funds for the health sector, less than 2 per cent of the national budget in 1994. In addition, 70 per cent of the

health budget is allocated to salaries and 20 per cent for other recurrent costs in hospitals.

6. The prevalence of stunting, which is among the highest in Africa, is 51 per cent of children under the age of five years. Breast-feeding prevalence is estimated at 97 per cent, but only 45 per cent of newborns are breast-fed from the first day and only 6 per cent within the first hour. Child growth faltering among young children occurs between 5 and 12 months of age owing to a combination of recurrent infections and poor weaning practices. More than 9 million people live in iodine deficient areas and the goitre rate varies between 35 and 67 per cent according to data from sentinel sites. Recent surveys estimate night-blindness - a sign of vitamin A deficiency - at about 3 per cent among children under five years old. Iron deficiency anaemia is one of the five main causes of morbidity among pregnant women. Around 35 per cent of households face food insecurity owing to declining purchasing power, rising costs of basic food commodities, low productivity of traditional agricultural practices, poor marketing and inadequate transport.

7. Access to safe drinking water has increased slightly between 1980 and 1991 from 20 to 23 per cent. However, there has been a significant reduction in access in urban areas from 80 per cent in 1980 to 55 per cent in 1991; 9 per cent of the rural population have access to safe drinking water. In 1991, 3 per cent of households had access to sanitary means of excreta disposal. The lack of effective policies, as well as insufficient empowerment of communities, has led to a gradual but steady decline in the maintenance of facilities. Soil erosion reduces the area of cultivatable land and leads to the silting of slopes and lowlands. Bush fires and deforestation deplete the green cover that facilitates water percolation and, therefore, limits the availability of water in aquifers.

8. Between 1980 and 1990, gross primary school enrolment declined from 142 to 92 per cent; net enrolment is about 65 per cent. Available data suggest that the adult literacy rate of 80 per cent in 1990 has diminished to 60 per cent nationwide and only 40 per cent in rural areas. The importance of maternal education as a child survival strategy is supported by the results of a recent national survey: a child whose mother has received no education is three times more likely to die before the age of five years than a child whose mother has completed secondary education or more. However, at the primary school level, completion rates are around 45 per cent. Among the main causes of low completion are inadequate curriculum, lack of classroom equipment, inappropriate basic education policies and lack of decentralized management. Furthermore, the coverage of informal educational systems is not sufficiently synchronized with the number of children who drop out of the formal system. However, no significant gender disparity exists at the primary school level. Moreover, girls generally obtain better examination results than boys. Literacy programmes have been affected negatively by policy changes, inappropriate pedagogy and administrative breakdowns during the recent political transition. Hence, adult illiteracy is probably on the rise from its estimated level of 40 per cent.

9. The number of children in especially difficult circumstances is troubling. Some of these children, including those who suffer from physical or mental handicaps, work in the informal sector and live on the streets. Several thousand girls work as prostitutes in the main cities. Young children from poor families are increasingly trapped into labour which is associated with severe exploitation, the absence of social protection and high health and nutritional risks. As a positive development, the Convention on the Rights of the Child was ratified by the Parliament in 1990, and Madagascar is one of the few countries reporting annually on its implementation. However, the lack of policies on the prevention of children in especially difficult circumstances puts children at risk and in need of strong social protection services.

10. Officially, women are regarded as equal to men, but their actual social and legal status often leaves them in virtual subjugation. Tradition and custom are largely opposed to the equality of women, to their participation in decision-making and to recognition of their economic roles.

11. With more than 500 non-governmental organizations (NGOs) and associations in the capital city alone and a nationwide network of religious organizations, Malagasy society plays an important role in social services delivery. However, the catalytic role of NGOs in promoting and sustaining social progress may be hindered by slow implementation of government decentralization policies.

12. In 1992, Madagascar established a constitution which sets forth democracy and liberalism as the basis for the legitimacy of the State. In 1993, a government programme was adopted which sets, among its priorities, a more equitable redistribution of economic growth and poverty alleviation. In 1994, with the assistance of UNICEF, the National Plan of Action for Social Recovery was launched. The National Plan of Action endeavours to combat poverty through the establishment of safety nets and structural changes in the management and coverage of basic social services, mainly for children and women. Strongly endorsing the goals of the World Summit for Children, it is meant to cushion against structural adjustment measures and aims at mobilizing an additional $600 million for the achievement of the decade goals for children.

13. Unfortunately, Madagascar is often confronted with emergency situations caused by cyclones, floods or droughts. Such cyclical emergencies seriously disrupt basic social services and jeopardize investments in the social sectors.

PROGRAMME COOPERATION, 1990-1995

14. As a result of the political instability of the early 1990s and its negative impact on programme implementation, the 1993 mid-term review proposed a bridging programme for the period mid-1994-1995 (E/ICEF/1994/P/L.19), as a link between the 1990-1994 and the 1996-2000 country programmes. This short-duration programme aimed at supporting strategies and activities required to achieve the mid-decade goals for children.

Health

15. A new orientation for primary health care (PHC) activities has been gradually introduced in the programme. In 1993, the adoption of Fahasalamana Iraisam Bahoaka (Bamako Initiative) as a strategy made the ideal of community-based, integrated PHC services a reality. The cooperation has provided an opportunity to start the new approach, with support of other donors and NGOs.

Nutrition

16. UNICEF has assisted with the identification of nutritional problems and the strengthening of national capacities for management and monitoring. Approximately 700 health and agricultural workers received training in nutrition, including for the Baby-Friendly Hospital Initiative (BFHI) and the control of iodine deficiency disorders (IDD). Activities to alleviate malnutrition and household food insecurity were gradually expanded to locations where PHC and integrated area-based projects were implemented. Beginning in 1987, a pilot project on nutrition education, linked with agricultural production activities, covered the Fénerive-Est region. The aim was to improve the nutritional status of children and introduce new crops. Health and nutrition education were incorporated into the school curriculum and pedagogical materials and supplies were produced.

Education

17. UNICEF assisted the Ministry of Population with early childhood development activities through the training of NGO personnel and provided equipment for adult literacy centres.

Area-based activities

18. An area-based programme was developed in the south-east. Using a strategy for community participation, the programme promoted agricultural activities for increasing family income and food security. Activities included the establishment of irrigated areas, nutritional recuperation centres and village wells, and the rehabilitation of health infrastructures. Some 150 wells were drilled.

19. UNICEF supported urban day-care centres which offered educational and pre-vocational training activities for young children and teenagers in difficult circumstances and facilitated their enrolment in school. UNICEF also supported improvement of sanitation facilities in Antananarivo. Activities involved partnerships with NGOs and community associations.

Social mobilization

20. The main social mobilization and communication themes centred around EPI, the Convention on the Rights of the Child, promotion of the Bamako Initiative to revitalize the PHC network and protection of the environment. Communication techniques for programmes are not well known in the country. Moreover, the vertical organization of the social mobilization programme has hindered the integration of information, education and communication (IEC) activities into sectoral programmes. Communication support was not sufficiently adapted to local socio-cultural situations, nor was it sufficiently geared towards community empowerment.

Emergencies

21. Since 1986, UNICEF has assisted with six emergency situations, such as cyclones, droughts, flooding, civil disturbances and wide-scale food poisoning. Much remains to be done to strengthen emergency preparedness and coordination of post-emergency rehabilitation services.

Cooperation with partners

22. The main donors of supplementary funds have been the Government of the United States, Rotary International and the Canadian, German, Finnish, French and Netherlands National Committees for UNICEF. In collaboration with the Netherlands National Committee for UNICEF, the Central Bank of Madagascar and ING Bank, part of the country's commercial debt was converted to supplementary funding. Thus, $8 million (in local currency equivalent) has been made available for programme activities, including emergency relief and rehabilitation operations. Collaboration with the World Bank has accelerated progress towards universal salt iodization.

Lessons learned

23. A number of lessons emerged from the cooperation. There should be a stronger linkage between programmes so as to prevent excessive vertical organization of programmes and projects. Objectives were not sufficiently quantified. There is also a need for more measurable social impact of the area-based programme. Insufficient programme support was given to major requirements such as water supply and sanitation, children in especially difficult circumstances, planning, monitoring and evaluation. More

cost-effective social mobilization activities are required. Support to women in development activities should be planned more systematically and integrated into the programme of cooperation.

24. The following will continue to be used in the new country programme: (a) the adoption of cross-cutting as well as sectoral strategies; (b) the formulation of quantified and time-bound targets; (c) an integrated monitoring and evaluation plan; (d) a greater involvement of communities in project design, management and implementation; and (e) more rigorous coordination of UNICEF assistance with other donors, United Nations agencies and NGOs.

25. In August 1993, the government health policy established a PHC centre in every village, with curative, preventive and promotional services, including EPI and ORT. This policy initiative reflects growing political stability, strengthening of democratic institutions and decentralization of public administration. The provision for more responsive PHC offers an opportunity to improve implementation of future cooperation.

RECOMMENDATION FOR ADDITIONAL GENERAL RESOURCES FOR THE APPROVED COUNTRY PROGRAMME, 1990-1995

Annual funding requirements

(In thousands of United Sates dollars)

Current programme cycle	Approved general resources funding a/	Additional funding proposed 1995	Total
1990-1995	4 322	165	165

a/ The amount shown here includes the actual balance carried over from the previous programme cycle.

26. In 1994, the Executive Board approved a short-duration ("bridging") programme for the period mid-1994-1995 in the amount of $4,322,000 from general resources and $7,400,000 in supplementary funding (E/ICEF/1994/P/L.19). Additional general resources were provided for achievement of the mid-decade goals for EPI, ORT and vitamin A deficiency. Therefore, additional general resources are requested in the amount of $165,000 to meet the approved level for 1995. This amount will be distributed mainly among the various projects within the health programme in order to accelerate progress towards achievement of the mid-decade goals.

RECOMMENDED PROGRAMME COOPERATION, 1996-2000

General resources : $15,900,000
Supplementary funding: $44,100,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health	4 900	14 730	19 630
Nutrition	1 500	3 500	5 000
Education for all	2 700	10 900	13 600
Water supply, sanitation and environment	2 000	7 500	9 500
Children in especially difficult circumstances	1 250	3 250	4 500
Information and communication	1 000	2 970	3 970
Planning and social statistics	2 550	1 250	3 800
Total	15 900	44 100	60 000

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

Country programme planning process

27. Government agencies, donors and NGOs have collaborated at each stage of the programming process, including milestone meetings devoted to the analysis of the situation of children and women, the development of a country programme strategy and the review of proposed programme plans of operations. Strategies to contribute to the achievement of the decade goals, as expressed in the National Plan of Action for Social Recovery, have been formulated and drew on the recommendations of the multi-donor evaluation of UNICEF as well as on the country's development priorities. Other national initiatives, the National Programme of Action for the Environment and the National Nutrition Plan of Action, also provided important references for the proposed cooperation.

Goals, objectives and strategies

28. The long-term goal of the country programme is the effective implementation of the Convention on the Rights of the Child. Madagascar's pursuit of economic and social recovery has a major impact on the country programme. In this context, the objectives are threefold. First, the cooperation will facilitate achievement of the goals of the World Summit for Children, as endorsed by the National Plan of Action for Social Recovery. These include (a) to reduce IMR by 24 per cent to 76 per 1,000 live births and U5MR by 32 per cent to 111 per 1,000

live births; (b) to reduce MMR by 50 per cent to 285 per 100,000 live births; and (c) to reduce severe and moderate malnutrition among children under five years old by one half to 20 per cent. Second, the cooperation will help to revitalize basic services through policy and institutional development, capacity-building, service delivery and community empowerment activities. For example, the Bamako Initiative will provide PHC to 30 per cent of the population by the year 2000. Third, the programme of cooperation will help to strengthen resource mobilization with the Government, donors, NGOs and communities.

29. The country programme has interrelated sectoral and cross-cutting strategies. Each sectoral strategy (health; nutrition; water supply, sanitation and environment; basic education; children in especially difficult circumstances) has elements of service delivery, policy development, capacity-building, community empowerment and advocacy. In terms of geographic coverage, priority will be given to locations with inadequate basic services, low socio-economic status, demonstrated community-driven initiatives and a convergence and complementarity between the country programme and support provided by other donors.

30. The convergence of service delivery is one of five cross-cutting strategies for guiding the delivery of basic services to the target populations, achieving economies of scale and creating development centres. Convergence will be reinforced by linkages among strategies for sectoral programmes such as the Bamako Initiative in health and an assessment-analysis-action ("triple A") approach in nutrition. Thus, one programme will also serve as an entry point for other basic services. A second cross-cutting strategy relates to partnerships, in particular with local and international NGOs, United Nations agencies and bilateral organizations. Community-based management committees will be established for all programmes associated with UNICEF assistance. The involvement of women in planning, implementation and monitoring will be promoted systematically.

31. A strategy for the protection of the environment will entail four interrelated elements: (a) advocacy for a stronger linkage between protection of the environment and social development; (b) use of cost-effective, environmentally friendly technologies; (c) promotion of more efficient agricultural practices; and (d) more environment-sensitive school curricula. The strategy for social mobilization will aim at increasing the demand for basic services and obtaining popular support for revitalization processes. Communication strategies will combine interpersonal communication using community facilitators and the dissemination of messages through national media, including rural radio. National and local communication strategies will intertwine to blend community assessment of needs and solutions and national institutional responses. Another cross-cutting strategy will be the development of an integrated monitoring and evaluation plan.

32. The proposed country programme presents a streamlined structure, featuring seven sectoral programmes with 19 projects, compared to 28 projects in the previous programme of cooperation.

Health

33. The health programme will contribute to the eradication of poliomyelitis and the reduction of mortality due to measles, diarrhoea and ARI. The programme will also provide access to PHC for 30 per cent of the population by 2000 and reduce the prevalence of STDs by 50 per cent. Together with IEC activities on AIDS, the reduction of STDs will help to prevent HIV infection. Increasing access to PHC services through the Bamako Initiative will emphasize management decentralization; a minimum package of essential curative, preventive and promotional health care; increased availability and more rational use of essential drugs and equipment; and community participation in management.

34. Thus, the Bamako Initiative will revitalize 360 peripheral health centres located in all the provinces by 2000. UNICEF will support the building of relevant managerial capacities at district and provincial levels, as required. UNICEF will also support and promote more effective coordination and advocacy for resource mobilization with donors, in addition to assistance for the revitalization of all 1,200 health centres targeted by the National Plan of Action for Social Recovery. UNICEF will assist the Ministry of Health with essential drugs and medical supplies; training of health workers, district managers and health committees; logistical equipment; and the development of managerial, monitoring and social mobilization tools. Community financing will cover local operating costs, excluding health worker' salaries. Ensuring equitable access to services through operational research and the promotion of solidarity will be a priority.

35. EPI and maternal and child health coverage will be sustained and further enhanced in areas where the Bamako Initiative is not yet operational. However, activities will decrease progressively as peripheral health centres are revitalized. EPI, control of diarrhoeal diseases and BFHI activities will be a high priority for national coverage. STD and AIDS prevention will increase the knowledge of in-school and out-of-school teenagers (10-14 years old) on reproductive health and prevention and promote more responsible sexual behaviour in young adults in urban and peri-urban areas.

Nutrition

36. The programme will contribute to achievement of the goals for protein-energy malnutrition, micronutrient deficiencies, growth monitoring and promotion, promotion of exclusive breast-feeding and household food security. The empowerment of communities to better analyse, assess and respond to child malnutrition will cover 200 communities, with 300,000 children under five years old and 270,000 pregnant and lactating women. This coverage will converge with coverage of the Bamako Initiative, thereby optimizing the impacts of maternal and child care interventions and community-based growth monitoring and promotion activities. UNICEF will also support activities for household food security, reduction of womens' workload and environmental hygiene.

37. Micronutrient deficiencies will be addressed through supplementation, the promotion of dietary diversification and fortification of food with vitamin A, iodine and folic acid. A major target will be to sustain nationwide iodation of salt. UNICEF cooperation will complement World Bank support to iodize all locally-produced salt and eliminate IDD. Iodine supplementation will be confined to those few highly endemic areas where iodated salt may not be available.

Education for all

38. The primary aim of the cooperation will be to revitalize the primary school system through improved educational policies which emphasize decentralization, community empowerment and participation, increased partnerships with local NGOs, national as well as subnational capacity-building and improvement of curricula. Another initiative will revitalize 1,000 primary schools serving approximately 150,000 children. This coverage would contribute to achieving 10 per cent of the goal of an 80 per cent completion rate. Improving management standards, building community management capacities and improving cost-effectiveness of teaching and learning materials are important strategies. Collaboration among communities, parent associations, educational authorities and NGOs will generate local solutions to the problems of each school.

39. Non-formal education provides alternatives where the formal system is still ineffective in promoting pre-school education and early childhood stimulation activities as strategies to improve primary school enrolment and achievement.

In addition, literacy activities will serve young adults, especially women, who have not completed a primary education. There will be close collaboration with the United Nations Educational, Scientific and Cultural Organization, the International Labour Organisation, the World Bank and French and Japanese bilateral aid programmes.

Water supply, sanitation and environment

40. The programme will help to (a) increase access to sanitary means of excreta disposal by 30 per cent to 52 per cent; (b) increase access to safe drinking water by 25 per cent to 66 per cent; and (c) promote environmental care activities in convergence with other programmes. The strategy is to sensitize communities about their interdependence with the environment and to ensure that basic services are managed in an environmentally-conscious manner.

41. The sanitation project will use IEC activities to promote better individual and collective hygienic behaviour; support the installation and maintenance of 25,000 latrines for 150,000 people, mainly in urban areas; and develop recycling systems. The water supply project will establish 650 community-operated water points in rural areas for 205,000 people. UNICEF will assist in the supervision of 650 community management committees, help to establish decentralized maintenance networks and support monitoring systems using World Health Organization/UNICEF guidelines. National capacity-building will include the rehabilitation of drilling units and the training of drilling teams and social mobilization agents. The private sector will be encouraged to invest in maintenance and drilling operations. The primary environmental care project will assist other programmes to establish replicable, model environmental actions such as market gardening, nurseries and reforestation.

Children in especially difficult circumstances

42. This programme will attempt to promote the protection of vulnerable children and to strengthen rehabilitation of services. The programme will start in Antananarivo and Antsirabe and progressively expand coverage to the cities of Fianarantsoa, Tulear, Mahajanga, Tamatave, Fort Dauphin and to 50 additional towns. More than 165,000 children and 50,000 single mothers will be covered. One initiative will emphasize prevention through partnerships with NGOs and social institutions. Another initiative will provide basic services for street children, delinquents, commercial sex workers and handicapped children. Vulnerable households will participate in services related to income generation, credit, land tenure and residential security and community organization.

Information and communication

43. Advocacy will pursue the challenging tasks of improving the linkages between policies and budgetary allocations for children and mothers, especially to promote implementation of the National Plan of Action for Social Recovery. Target groups will include donors, mass media, traditional opinion leaders, artists and intellectuals, associations, trade unions, mayors and other political leaders. A second priority will be to reduce gender disparities from both institutional and cultural causes and to promote women in development activities. Programme communication support will strengthen strategies for behavioural change through print and audio-visual materials for advocacy, IEC and social mobilization activities in all programmes.

Planning and social statistics

44. The planning and social statistics programme will strengthen the programming and coordination capacities of national and subnational authorities in the implementation of the country programme and the National Plan of Action for Social Recovery. The programme will improve regular monitoring of country

programme inputs and accomplishments. Regular monitoring of the situation of children, women and other vulnerable groups will also be a priority. A sentinel sites surveillance network, operated by the National Food and Nutritional Surveillance Programme, will provide timely assessments of the impact of adjustment policies at the household level. More innovative and efficient methods of measurement will be employed to assess the contribution of UNICEF cooperation to achievement of the decade goals. There will be closer cooperation with bilateral and multilateral agencies already involved in socio-economic planning such as the United Nations Development Programme (UNDP), the United States Agency for International Development, the European Union and French Cooperation.

45. Emergency preparedness and response activities will help to alleviate devastation from natural disasters such as cyclones and droughts. A timely warning system operated through the National Food and Nutritional Surveillance Programme sentinel system will be linked with mechanisms for the stockpiling and distribution of supplies, logistical support and communications. UNICEF will also support policy development, capacity-building and service delivery strategies so that emergency and rehabilitation services better meet the needs of victims.

Programme management

46. The Ministry of Planning, through the Directorate of Planning, and in liaison with the Ministry of Foreign Affairs, will ensure the coordination of country programme implementation. Coordination with multilateral and bilateral donors will strengthen the complementary role of UNICEF cooperation and strengthen programmatic linkages with the assistance of other donors.

47. UNICEF will continue to advocate for and participate actively in the development of a country strategy note for government cooperation with United Nations agencies as well as to promote harmonization of programme cycles with UNDP and the United Nations Population Fund. Collaboration with NGOs will include project agreements which define the roles and responsibilities of NGOs and UNICEF. Local communities will be crucial partners, providing essential inputs such as commodities and other kinds of participation. Communities will be involved in co-management, maintenance and cost-sharing activities, as well as in the promotion of access to basic services for all.

48. The proposed level of supplementary funding is based on past fund-raising success. Supplementary funds will usually complement general resources to further expand the coverage of basic services and support activities in the areas of communication, advocacy and social statistics. A fund-raising strategy has been prepared which stresses the importance of pursuing and further developing the commercial debt-swap experience for supplementary funding. Information exchanges with existing and potential donors will be organized, in particular with National Committees for UNICEF. New partnership arrangements will be sought with the national private sector and multinational companies.

49. An important objective is to build the capacity of UNICEF national professional officers for strengthening continuity of programmes. A special effort will be made to recruit more female staff members during the new programming cycle, particularly for professional posts. Currently, 34 per cent of National Professional Officer posts and 53 per cent of General Service posts are held by women.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Madagascar	(1992 and earlier years)		UNICEF country classification
Under-five mortality rate	164	(1993)	Very high U5MR
Infant mortality rate	100	(1993)	Very high IMR
GNP per capita	$ 230	(1992)	Low-income GNP
Total population	13.3 million	(1993)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1990	1993
Births	(thousands)	314	404	553	604
Infant deaths (under 1)	(thousands)	58	56	55	60
Under-five deaths	(thousands)	89	87	91	99
Under-five mortality rate (per 1,000 live births)		285	216	164	164
Infant mortality rate (under 1) (per 1,000 live births)		184	140	100	100

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1984/1992))	Moderate & severe	33 *	39 *
	Severe	8 *	9 *
Babies with low birth weight (%, 1986)		..	10
Primary school children reaching grade 5 (%, 1970/1990)		42	38

NUTRITION INDICATORS	About 1980	Most recent
Exclusive breast-feeding rate (<4 mos.) (%, 1992)	..	47
Timely complementary feeding rate (6-9 mos.) (%, 1992)	..	93
Continued breast-feeding rate (20-23 mos.) (%, 1992)	..	45
Prevalence of wasting (0-59 mos.) (%, 1984/1992)	12 *	5 *
Prevalence of stunting (0-59 mos.) (%, 1984/1992)	28 *	51 *
Daily per capita calorie supply (% of requirements, 1979-1981/1988-1990)	109	95
Total goitre rate (1990)	..	24
Household expenditure (% of total income, 1980-1985) All food/cereals	..	59 / 26

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1986/1992)		12	29
Access to health services	Total	60	65
(% of population, 1980/1989)	Urban/rural	.. / ..	65 / 65
Access to safe water	Total	20	23
(% of population, 1980/1991)	Urban/rural	80 / 7	55 / 9
Access to adequate sanitation	Total	..	3
(% of population, 1980/1991)	Urban/rural	9 / ..	12 / 3
Births attended by trained personnel (%, 1992)			56
Maternal mortality rate (per 100,000 live births, 1988)		..	570

Immunization		1981	1985	1990	1993
One-year-olds (%) immunized against:	Tuberculosis	25	31	67	82
	DPT	40	23	46	64
	Polio	..	20	46	64
	Measles	..	28	33	52
Pregnant women (%) immunized against:	Tetanus	..	22	60	16

* Aged 0-23 months.

/...

TABLE 1 (continued)

Madagascar

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net) (%, 1980/1990)	Total	142 / ..	92 / ..
	Male	145 / ..	93 / ..
	Female	139 / ..	91 / ..
Secondary enrolment ratio (gross/net) (%, 1980/1990)	Total	.. / ..	18 / ..
	Male	.. / ..	18 / ..
	Female	.. / ..	18 / ..
Adult literacy rate, 15 years & older (%, 1985/1990)	Total	77	80
	Male/female	86 / 68	88 / 73
Radio/television sets (per 1,000 population, 1980/1991)		182 / 5	200 / 20

DEMOGRAPHIC INDICATORS		1970	1980	1990	1993	2000
Total population	(thousands)	6745	8790	12010	13259	16579
Population aged 0-15 years	(thousands)	3070	4076	5686	6328	7910
Population aged 0-4 years	(thousands)	1165	1551	2188	2439	2914
Urban population (% of total)		14.1	18.3	23.8	26.0	30.8
Life expectancy at birth (years)	Total	45	50	54	56	58
	Male	44	49	53	54	57
	Female	47	52	56	57	60
Total fertility rate		6.6	6.6	6.6	6.6	5.9
Crude birth rate (per 1,000 population)		47	46	46	45	42
Crude death rate (per 1,000 population)		20	16	13	13	10

		About 1980	Most recent
Contraceptive prevalence rate (%, 1992)		..	17
Population annual growth rate (%, 1965-1980/1980-1993)	Total	2.5	3.2
	Urban	5.1	5.9

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate (%, 1965-1980/1980-1992)		-0.4	-2.4
Inflation rate (%, 1970-1980/1980-1992)		10	16
Population in absolute poverty (%, 1977)	Urban/rural	50 / 50	.. / ..
Household income share (%)	Top 20%/bottom 40%	.. / ..	.. / ..
Government expenditure (% of total expenditure, 1991)	Health/education	.. / ..	7 / 17
	Defence	..	8
Household expenditure (% share of total, 1980 or 1985)	Health/education	.. / ..	2 / 4
Official development assistance: (1981/1992)	$US millions	184	359
	As % of GNP	7	13
Debt service (% of goods and services exports, 1982/1992)		20	16

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1990-1995 a/

COUNTRY: MADAGASCAR
LATEST BOARD APPROVAL: 1990
GENERAL RESOURCES: $16 822 000

(In thousands of United States dollars)

Programme sectors/areas	Supplies and equipment (actual)		Training grants (actual)		Project staff (actual)		Other cash (actual)		TOTAL					
									General resources		SF		Total (GR & SF)	
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Actual	Planned	Actual	Planned	Actual	Planned
Health	4 870	3 324	286	199	183	74	819	3 114	6 158	5 728	6 711	15 178	12 869	20 906
Nutrition	777	188	49	59	82	49	263	524	1 171	2 445	820	4 200	1 991	6 645
Water supply and sanitation	22	7		47			825	946	847		1 000		1 847	
Education	345	173	176	81	141		329	452	991	1 325	706	4 605	1 697	5 930
Community organization and development	104	212	15	11			70	605	189		828		1 017	
Young child development										400		750		1 150
Women-centred programme		5									5		5	
Children in especially difficult circumstances	1	558		23		128	1	338	2		1 047		1 049	
Social mobilization and advocacy	49	42	6	11	16		130	54	201	367	107	840	308	1 207
Planning and social statistics	34	96		38			37	63	71		197		268	
Programme support	641	53	99		1 979	288	1 222		3 941	3 862	341		4 282	3 862
Emergency	356	422	23	2			354	1 122	733	2 695	1 546	6 827	2 279	9 522
GRAND TOTAL	7 199	5 080	654	471	2 401	539	4 050	7 218	14 439 b/	16 822 c/	13 308	32 400 d/	27 612	49 222

GR = General resources.
FSF = Programmes approved for funded supplementary funding.
SF = Programmes for supplementary funding, funded and unfunded.

a/ Actual expenditures include expenditures recorded as of November 1994.

b/ Including expenditures from global fund and additional allocation of general resources for unfunded programmes for supplementary funding.

c/ Including additional general resources of $4 322 000 (E/ICEF/1994/P/L.19).

d/ Of this amount, $6 860 963 remains unfunded.

TABLE 3. PLANNED EXPENDITURE, 1996 - 2000

(In thousands of United States dollars)

Country: MADAGASCAR **Period covered: 1996 - 2000**	**Funding status**	**1996**	**1997**	**1998**	**1999**	**2000**	**Total**
Health	GR	900	1 000	1 000	1 000	1 000	4 900
	NSF	3 010	2 910	2 970	2 970	2 870	14 730
Nutrition	GR	300	300	300	300	300	1 500
	NSF	700	700	700	700	700	3 500
Education for all	GR	500	550	550	550	550	2 700
	NSF	2 000	2 050	2 150	2 250	2 450	10 900
Sanitation, water and environment	GR	400	400	400	400	400	2 000
	NSF	1 500	1 500	1 500	1 500	1 500	7 500
Children in especially difficult circumstances	GR	250	250	250	250	250	1 250
	NSF	650	650	650	650	650	3 250
Information and communication	GR	200	200	200	200	200	1 000
	NSF	650	580	580	580	580	2 970
Planning and social statistics	GR	550	500	500	500	500	2 550
	NSF	250	250	250	250	250	1 250
TOTAL	GR	3 100	3 200	3 200	3 200	3 200	15 900
	NSF	8 760	8 640	8 800	8 900	9 000	44 100
GRAND TOTAL		11 860	11 840	12 000	12 100	12 200	60 000

GR = General resources.
NSF = New programmes for supplementary funding.

Annex

LIST OF STUDIES AND EVALUATIONS, 1993-1994

1. Establishment of salt iodization plants at Toliary and Morondava and enactment of regulations on iodized salt, 22 March 1993.

2. Evaluation of ENAP (pedagogical and costing), January 1994.

3. Cost, resource, use and financing of district health services, August 1994.

4. True coverage: study to evaluate the cold chain and determine the seroconversion of children and women, late 1994.

5. Development of the conceptual framework for causes of malnutrition, July 1994.

6 National survey on the situation of children and women, October 1992.

7. Evaluation of the Manakara-Vohipeno integrated project, 1 February 1993.

8. "Child by child" participatory evaluation of the Antoka NGO project for resettling street children in rural areas.

9. Vitamin A deficiency: study and mapping of its incidence, April 1994.

10. Study on the cost dimension of community participation, 15 April 1993.

11. Study on the managerial capacity of women's groups, 4 October 1993.

12. Survey on vaccination coverage, 11 July 1993.

13. Survey on the motivation of health personnel, 11 July 1993.

14. Surveys on knowledge, attitude and practices with respect to nutrition in the Antananarivo and Toliary "Faritany", 25 January 1993.

15. Introduction of universal salt iodization in Madagascar, 24 October 1993.

16. Survey to evaluate the food and nutrition situation of the Brickaville "Fivondronana", July 1994.

17. Feasibility study on salt iodization in Madagascar, December 1993.

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FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Uganda

SUMMARY

The Executive Director recommends that the Executive Board approve the country programme of Uganda for the period 1995 to 2000 in the amount of $32,600,000 from general resources, subject to the availability of funds, and $77,400,000 in supplementary funds, subject to the availability of specific-purpose contributions.

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* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1994, will be contained in the "Summary of 1995 recommendations for general resources and supplementary funding programmes" (E/ICEF/1995/P/L.10 and Add.1).

/...

THE SITUATION OF CHILDREN AND WOMEN

1. After the strife of the 1970s and 1980s, the past five years have brought new hope for children and women in Uganda. Many socio-economic indicators still reflect the difficulties of past decades, but peace and stability have returned. After years of decline, economic growth is accelerating; it reached 7.2 per cent in 1992-1993. Inflation fell from over 250 per cent in 1989 to 16 per cent in 1993-1994. In spite of these achievements, per capita gross domestic product (GDP) is still less than $200 per annum, and 57 per cent of the population cannot afford the minimum caloric intake and basic non-food items. Major constraints to equitable growth include a debt of $2.6 billion, very low revenue generation through taxation (9.5 per cent of GDP) and limited employment opportunities outside the agricultural sector. The Government's low revenue base constrains investment in the social sector. While approximately one third of government expenditure goes to the social sector, only one third of this is spent on basic services. Government expenditure on health has increased to 5 per cent of GDP, but most expenditure is still mainly on curative care and for towns. A similar pattern exists in education.

2. Uganda's population in 1991 was 16.6 million, and it is increasing at an annual rate of 2.5 per cent. Ninety per cent of the people live in rural areas. Fifty per cent are under 15 years of age. Uganda has 39 districts, 150 counties, about 800 sub-counties, 4,800 parishes and 40,000 villages. The political structure consists of democratically elected Resistance Councils, and they range from the village to the national level. At least one female representative is appointed at each level. This system has contributed to political stabilization and has also mobilized people around social priorities such as immunization. The Resistance Councils are the principal channel for the national Government and community participation processes of development. Parallel to the Resistance Council system runs the administrative structure of civil servants and extension workers who, though still poorly paid, are becoming more accountable to elected councils under a new decentralization policy. Despite some constraints, more decentralization of authority to local Government is expected to lead to a much needed acceleration of the development process at district and sub-country levels.

3. The Uganda National Programme of Action for Children (UNPAC) embodies the country's political commitment to address the problems of women and children. Providing a policy framework for social sector planning, UNPAC sets 16 major goals and 59 supporting goals for the survival, development and protection of children by the year 2000. The National Council for Children (NCC), established in 1993, has begun to decentralize UNPAC to the district level and below.

4. The 1991 census revealed an infant mortality rate (IMR) of 122 per 1,000 live births, no improvement on the last reliable figure of 1969. The under-five mortality rate (U5MR) has also remained stagnant at 203 per 1,000 live births. The main causes are malaria, measles, diarrhoea, pneumonia and acquired immune deficiency syndrome (AIDS). Recent increases in the incidence of malaria and AIDS underscore the inadequacy of disease prevention and access to basic health services.

5. There is no evidence of significant improvement in nutrition. Over 10 per cent of babies are born with low birth weight. Forty-five per cent of children under the age of five years are moderately or severely stunted. This is the result of the high incidence of childhood infections, insufficient frequency of feeding and, especially in urban areas, declining breast-feeding and child care practices. The heavy workloads of mothers may interfere with the proper feeding of young children, and the youngest are usually given lowest priority at meals. Many families suffer from food shortages and poor food storage practices because they have to sell staple foods to raise cash for other basic family expenses.

6. The maternal mortality rate (MMR) is estimated at 300 per 100,000 live births, which is among the highest in the world and shows no sign of declining. Contributing factors are the 67 per cent incidence of adolescent pregnancies, the 62 per cent of deliveries made without trained attendants and the high fertility rate (7.3). Girls are often married before physical and social maturity, and early child-bearing repeated at short intervals contributes to premature exhaustion. Many traditional families prefer their sons to marry uneducated girls. As a result, many families arrange early marriages to secure a bride-price for their daughters. Girls are also expected to contribute to family income until they leave home to marry. Therefore, they are less likely to be educated than boys, and investment in girls' education is often seen as wasted. Girls and women bear heavy multiple burdens of child care, domestic chores, water and fuelwood collection, food production for consumption and sale, and other activities to secure the bulk of family income. In most cases, the husband controls and allocates family resources even though the woman does most of the work to generate these resources.

7. Safe rural water supply coverage was less than 5 per cent in 1980, rose to 28 per cent in 1992, and continues to improve. However, this remains one of the lowest coverage rates in the world and it contributes to the high rates of diarrhoeal diseases and parasitic infections as well as to the excessive workload of girls and women. Inappropriate use of water also limits its potential health benefits. Unprotected sources are often preferred to boreholes because of their convenience and taste. Water handling and storage are often unhygienic; water from safe sources becomes polluted by the time it is consumed. Sanitation awareness is low and the construction of a family latrine is often considered an unnecessary expense. Rural sanitation coverage in 1992 was reported to be 52 per cent.

8. The social and economic impact of human immunodeficiency virus (HIV)/AIDS is undermining the prospects for more progress in child survival. National HIV sero-prevalence is estimated at 10 per cent, but reaches 30 per cent in some areas. AIDS-related deaths overwhelm the caring capacity of the population and leave behind dependent orphans and the elderly, whose needs strain the capacity of a depleted social services system. HIV infection among girls is six times higher than among boys owing partly to the exploitation of young girls by older men seeking HIV/AIDS-free partners. Physical and sexual abuse of women and girls is widely reported. Adolescent pregnancy frequently leads to expulsion from school. There are an estimated 1.2 million orphans who depend on the extended family and community support. The number of street children is also rising and child labour is common.

9. Government expenditure on primary education is increasing, but reached only 2 per cent of GDP in 1992-1993. The enrolment rate has fallen by nearly 2 per cent over the last four years. There is a considerable disparity between urban and rural facilities. Poverty is the main cause of low enrolment (87 per cent for boys and 68 per cent for girls) and high drop-out rates (52 per cent for boys and 75 per cent for girls).

10. In conclusion, optimism arising from Uganda's political and macroeconomic recovery is justified but not sufficient in itself for major improvements in the difficult situations of women and children. Many appropriate policies and structures are in place, but a scarcity of resources creates a large gap between intention and implementation. Government decentralization presents both a challenge and an opportunity. All locally available resources, including those from donors, need to be incorporated into the district planning and budgeting processes for decentralization to succeed for children and women. Effective decentralization would bring decision-making and accountability closer to communities and lead to closer relationships between donors and districts. A major challenge will be to use external resources to mobilize more domestic resources and commitments, particularly at district, community and family levels, in pursuit of the UNPAC goals.

PROGRAMME COOPERATION, 1990-1994

11. The major objectives of the country programme were (a) to reduce IMR from an estimated 104 to 90 per 1,000 live births; (b) to reduce U5MR from an estimated 165 to 155 per 1,000 live births; and (c) to reduce MMR from 265 to 250 per 100,000 live births. The mid-term review in 1993 led to the incorporation of several mid-decade goals, including: (a) to raise immunization coverage to 80 per cent and that of measles to 90 per cent; (b) to eliminate neonatal tetanus; (c) to virtually eliminate iodine deficiency disorders (IDD) and vitamin A deficiency; (d) to achieve the use of oral rehydration therapy (ORT) in 80 per cent of episodes of child diarrhoea; and (e) to interrupt the transmission of dracunculiasis (guinea worm disease).

12. The 1991 census showed that previous estimates of mortality rates were low and that, therefore, the IMR and U5MR objectives were unrealistic. However, the programme made considerable progress towards coverage and disease-specific targets. The adoption of the mid-decade goals led to some progress. Measles immunization coverage reached 70 per cent in 1993, and the use of ORT almost tripled to 45 per cent. The number of reported cases of guinea worm disease fell from 120,000 in 1991 to 45,000 in 1993. However, much remains to be done to achieve the mid-decade goals by the end of 1995. Neonatal tetanus is still a significant cause of infant deaths. IDD are prevalent in five districts and a vitamin A deficiency survey revealed a xerophthalmia rate of 6 per cent in one district.

Health and nutrition

13. The main focus was continued support for immunization services through social mobilization, training and the provision of supplies and logistics. The achievement of universal child immunization (UCI) was remarkable in view of the neglected infrastructure, insecurity and low remuneration of staff. UCI reflects political commitment, sound management and effective social mobilization. UCI has led to an overall decline in the number and severity of measles epidemics. However, a recent drop in immunization coverage rates underscores the need for more sustainable approaches.

14. In spite of low media coverage, poor communications and difficulties faced by extension workers, the programme succeeded in tripling the ORT use rate for the treatment of diarrhoea. The programme integrated the delivery of services for the control of acute respiratory infections (ARI) to improve its cost-effectiveness.

15. Two nationwide health education programmes were established, one of them for schools. The area-based programme for health and water was expanded from 5 to 10 districts. The introduction of health financing schemes and management committees for health units has improved community participation in health and increased resources for health care at the local level.

Water supply and environmental sanitation

16. The objective was to protect 8,160 springs, drill 1,895 boreholes, rehabilitate 1,750 boreholes and construct 4,660 latrines. The achievements were 9,000 springs protected, 2,000 boreholes drilled, 1,800 boreholes rehabilitated and 63,500 latrines constructed. The UNICEF contribution was particularly prominent in the 10 districts of the area-based programme where water supply coverage reached 33 per cent and sanitation 66 per cent in 1992. After years of neglect, the proportion of operational water sources recovered reached 85 per cent in 1993 through the rehabilitation of boreholes and the development of a community-based maintenance system. Hence, the water supply and environmental sanitation programme was also a pioneer in demonstrating how the decentralization process can be supported by a donor-assisted programme.

17. Although sanitation coverage remains low, there was progress in raising political commitment. The programme moved away from the exclusive promotion of the ventilated improved pit latrines towards a policy of promoting simple, improved pit latrines. These are constructed entirely of local materials and use a low-cost latrine slab which is within the means of most families. Local production centres increased the availability of sanplats. Improved water supplies and effective health education led to solid progress in reducing transmission of endemic guinea worm disease.

HIV/AIDS prevention

18. The two major health education programmes were also the basis for the development of the country programme's response to the HIV/AIDS epidemic, known as safeguard youth from AIDS. This has now become a mainstream approach and is integrated into the government's multisectoral HIV prevention activities at national and district levels, as well as by non-governmental organizations (NGOs). A basic communication strategy encourages the adoption and sustained practice of health promotion and safe sexual behaviours by young people. The strategy emphasizes changes in values, beliefs and attitudes and other enabling factors. UNICEF promoted and supported the development of an association for NGOs involved in community-based child welfare. With its district branches, this association is now the major coordinating body for services for AIDS orphans.

Education

19. The programme supported the development of a viable health education component in the school syllabus, with associated teacher training and other support. The objective was for 75 per cent of children completing primary grade seven to answer correctly 65 per cent of the relevant questions from the syllabus. An evaluation is due in 1995, but a 1992 survey of 1991 results showed that 27 per cent of children answered 50 per cent of the questions correctly, an increase of 11 per cent over the previous year. The programme also supported functional literacy classes for women and pilot community mobilization initiatives to increase primary school enrolment, especially of girls.

Planning and advocacy

20. UNICEF supported the development of UNPAC and the ratification of the Convention on the Rights of the Child. Both raised public consciousness of children's issues, which are increasingly being addressed by planning processes at all levels. One indication of this was the Government's creation of NCC in 1993, which advocates and facilitates planning for children.

Lessons learned

21. The 1990-1995 country programme succeeded in improving basic health infrastructure and delivery systems and laid the groundwork for longer-term and sustainable changes in the situation of Ugandan women and children. In particular, the scope and effectiveness of centralized, vertical service delivery programmes such as immunization, the promotion of ORT, water supply and environmental sanitation, were improved considerably.

22. By 1994, over 40 evaluations and major studies had been conducted on programme impact and activities. All programmes went through at least one evaluation. In-depth studies also covered almost all aspects of the programme from guinea worm to equity for girls. Findings contributed to the annual programme reviews and led to adjustments in the plan of action for the following year. They were also considered at the 1993 mid-term review, which recommended increased attention to sustainability (including behaviour change), cost-effectiveness and gender equity.

23. The generic thrust of the evaluations was that high levels of external financial and technical assistance had brought about improvements in service delivery, but that project management units had been added to rather than integrated into existing government structures. This has contributed to a donor-dependent "project culture", and led to numerous centrally-based, supply-driven and vertical service delivery projects. This approach was less cost-effective and led to the duplication of activities, problems of coordination and lack of "ownership" of the programme at the district level. While knowledge and attitudes have improved, studies on AIDS awareness (1992), ORT practices (1993) and sanitation behaviour (1992) suggested that there has been limited measurable impact on behavioural change. Although increased women's participation in development was an objective of the 1990-1995 programme, the evaluations found little evidence of progress.

24. The increasing demands for external assistance and human resources has led to more efforts to mobilize local resources (Bamako Initiative evaluation, 1991) and to make child survival and development part of the mainstream of government activity. However, the proposed UNICEF country programme will need to give priority to greater coordination and cost-effectiveness through fewer projects and a more programme-focused approach (mid-term review, 1993). As most of the UNPAC goals depend on improving individual and family behaviours, the programme will need to move from information dissemination to community participation approaches for changing behaviours related to child survival, protection and development. Responsibility for gender issues will have to be more clearly assigned and monitoring systems will need to be more gender-responsive.

RECOMMENDED PROGRAMME COOPERATION, 1995-2000

General resources : $32,600,000
Supplementary funding: $77,400,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	General resources	Supplementary funds b/	Total
Health	8 000	26 400	34 400
Water supply and environmental sanitation	6 400	21 000	27 400
Basic education, child care and adolescent development	6 500	21 000	27 500
Coordination, communication and advocacy	4 700	7 500	12 200
Programme support	7 000	1 500	8 500
Total	32 600	77 400	110 000

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

Country programme planning process

25. There has been widespread participation in the development of the new country programme. A coordinating committee was formed in September 1993 consisting of senior members from relevant sectoral and multisectoral ministries, NCC, Makerere University, district administrations, United Nations agencies and international and national NGOs. The committee met monthly for one year. Four sectoral teams did the detailed work with planners and managers at different levels. The committee presented its findings to ministers and over 150 key partners, first, at the strategy meeting and then at the preview meeting. Virtually the same committee and its sectoral teams are expected to take on the role of coordinating implementation of the new programme.

26. In view of the changes in Uganda since the preparation of the last country programme, the committee decided to plan for the new programme to be introduced in 1995, in synchronization with the Government's 1995-1996 budget. This will allow restructuring of the current country programme to begin in 1995 and means that the previously approved country programme will conclude one year earlier than planned. It will also achieve harmonization with the programme cycle of the United Nations Development Programme, which will also conclude in 2000.

27. The development of the situation analysis was highly participatory. The process was led by NCC, with research and drafts prepared by the Child Health and Development Centre of Makerere University. This was the first time that a national institution rather than UNICEF has prepared the situation analysis. The research involved visits to every district and over 2,000 interviews and focus group discussions. The responses obtained, which were mainly qualitative in nature, provided a vital complement to the quantitative data provided by sectoral ministries and national institutions. NCC intends to update the situation analysis annually as a major advocacy activity.

Country programme objectives and national programme of action goals

28. The country programme has the following longer-term goals to guide the pursuit of specific objectives: (a) that all Ugandan children are born into a social environment that fully embraces their rights, is fully cognizant of their basic needs and makes all efforts to meet these needs with available resources; and (b) that, within their social environment, all Ugandan women and girl children enjoy the same rights as males to development opportunities and are freed from all forms of discrimination. As a country programme objective, UNICEF cooperation will support the development and implementation of district and sub-country plans of action for the achievement of the following UNPAC goals: (a) to reduce IMR from 111 per 1,000 live births in 1993 to 50 by 2000; (b) to reduce U5MR from 185 per 1,000 live births in 1993 to 70; (c) to reduce MMR from an estimated 300 per 100,000 live births to 250; (d) to reduce severe and moderate malnutrition among children under five years of age by 50 per cent; (e) to achieve 75 per cent access to safe water supply and environmental sanitation; and (f) to achieve 95 per cent primary school enrolment and 50 per cent completion, with equal enrolment and completion by boys and girls.

Strategies

29. The country programme strategy will have a more refined mix of strategies for advocacy and social mobilization, service delivery, capacity-building and community empowerment as a result of the lessons learned in the past cooperation. For example, strengthening service delivery is necessary but not sufficient for the development and implementation of district and sub-country plans of action for children. The achievement of UNPAC goals nationwide will also depend on changing and reinforcing community and family behaviours. These kinds of achievements can only be sustained with community institutions which are capable of implementing information, education and communication (IEC) activities.

30. Likewise, capacity-building to sustain services in cost-effective ways will depend heavily on improved cooperation among key government organizations for the improvement of multisectoral policies, e.g. for child nutrition, especially at district and national levels. Capacity-building efforts will be linked more systematically with communication activities to promote effective programme implementation with families, NGOs and the private economic sector. One example would be increasing production of iodized salt and promoting its use with the community.

31. The coverage of the country programme will be nationwide. Where activities are new, they will be developed in a limited geographic area and gradually expand towards national coverage. In districts receiving support for some activities from other donors, the country programme will focus on other complementary activities in the district.

32. The strategy of the country programme includes a structure with three major characteristics or dimensions. First, there are four levels at which behavioural changes and practices will be pursued. These are: (a) the community level, which is the most immediate environment of family behaviour change; (b) the service delivery level, where service providers interact with the community; (c) the district level, where resources are mobilized and managed for service delivery; and (d) the national level, for relevant policy and monitoring of policy implementation.

33. Second, the country programme is composed of four specific programmes: (a) health; (b) water supply and environmental sanitation; (c) basic education, child care and adolescent development; and (d) coordination, communication and advocacy. The last of these covers processes related to the mobilization of resources for the entire country programme.

34. Third, the programme is structured to promote six cross-cutting skills that government and NGO planners and managers need. These are gender analysis, information management, resource mobilization and management, communication, environmental analysis and the use of nutritional status as an indicator of programme performance. Improving the analytical skills of planners and managers will place capacity-building on gender issues in the mainstream of all programmes. These personnel will be better able to address gender throughout implementation, including the disaggregation of data and the planning of annual activities. Each programme includes discreet gender-specific activities that are designed to complement and reinforce follow-through on women's concerns. The strategy promotes not only women's participation as beneficiaries, but also their empowerment through increased control of and access to resources and women's involvement in decision-making.

Health

35. The health programme will aim to sustain the achievement of the mid-decade goals and support measures for the prevention and control of the leading causes of morbidity and mortality of women and children, i.e., malaria, ARI, diarrhoeal diseases, immunizable childhood diseases, reproductive health problems, malnutrition and micronutrient deficiencies. Specific targets include 85 per cent immunization coverage of infants, 33 and 50 per cent reductions in under-five mortality due to ARI and diarrhoea, respectively, and the reduction of malaria morbidity in pregnant women by 60 per cent.

36. The strategy will help communities to take more responsibility for health promotion. UNICEF will provide financial and logistical support to strengthen the capacity of 15,600 community committees. Information systems will be strengthened so that communities can monitor local basic health indicators. Based on monitoring results, advocacy and social mobilization will help to increase demand for the prevention, management and control of major diseases and

deficiencies. Activities will stress the correct treatment of the sick child, safe immunization, quality antenatal and maternity services, promotion of vitamin A-rich foods and exclusive breast-feeding during the first four months of life. UNICEF will support training for 145,000 community resource persons, community health workers and traditional birth attendants.

37. At the service delivery level, the strategy will be to develop an integrated package of essential health services and delivery systems and to strengthen related training and supervision of health workers. The package will emphasize the holistic management of the "sick child", especially for malaria, ARI and diarrhoea. Vitamin A supplementation and antenatal services will be delivered through integration with immunization services.

38. UNICEF will support the training of sub-county and district health managers so that they can identify and secure more resources and improve the use of resources. They will also be trained in health management information systems and sentinel community surveillance methodology. Thirty-nine district and 4,100 sub-county health committees will receive training in the better use of resources for health.

39. At the national level, UNICEF will support activities to develop and implement policy guidelines for a model district health system, integrated health service packages, promotion and importation of iodized salt, limitation on importation and use of breast-milk substitutes, provision of maternity shelters and improved gender analysis for women's empowerment. UNICEF will also support pre-service and in-service training of health personnel. Advocacy will sensitize decision makers at national and district levels to improve resource allocations for health services. Appropriate personnel will also be trained in logistics for emergency preparedness. The main national partners will be the Ministry of Health, the Uganda Community-Based Health Care Association and the Ministry of Local Government.

Water supply and environmental sanitation

40. This programme will contribute to achieving and sustaining 75 per cent access to 25 litres of safe water per capita per day within 1.5 kilometres. Ninety per cent of protected water sources will always be operational. Sanitary latrines will be used by 75 per cent of households. UNICEF assistance towards the achievement of this target will increase access for an additional 5.8 million people. The strategy will increase community management of the construction of water sources and sanitary facilities and promote the more effective use of these facilities to optimize their full health and social benefits. The water supply and sanitation projects of the past country programme will be incorporated into this programme to ensure a more holistic approach. UNICEF will assist nationwide, except in nine districts that are covered by another donor-supported programme, with priority to underserved areas. UNICEF assistance will also promote low-cost technology options. Surveillance of cases of guinea worm disease will be sustained for three years in order to certify eradication.

41. At the community level, Government, NGO staff and the private sector will provide technical assistance for programme implementation. Communities will plan, construct, monitor and maintain 23,260 water supply and sanitation facilities, of which over 75 per cent will use technologies other than boreholes. Hence the efficiency of service delivery systems should be improved by promoting greater responsiveness to community demands, needs and initiatives. In view of the strategy to accelerate coverage, capacity-building will focus on strengthening management skills for mobilization and management of resources at district and national levels. Training of 22,500 water source committees, 42,000 caretakers and 2,100 hand-pump mechanics will be conducted. As local capacity becomes more effective, UNICEF will concentrate more on long-term

sustainability. For example, national advocacy will seek to reduce disparities in the allocation of resources between urban and rural areas. UNICEF will also attempt to interest other donor support in the sector. The main national partners are the Directorate for Water Development and the Ministries of Health and Local Government.

42. During the last country programme, Uganda experienced natural and man-made disasters such as internal civil strife and sudden influxes of refugees. The water supply and environmental sanitation programme will in future be the focal point for emergency preparedness within the country programme. This will involve the preparation of emergency preparedness plans at the district level and early warning systems at the national level.

Basic education, child care and adolescent development

43. Basic education, child care and protection and HIV/AIDS prevention will be merged into one programme which will focus on the cognitive and psycho-social development of children from infancy to adolescence. This adjustment responds to recommendations of evaluations to use common approaches and resource persons, improve linkages and complementarity and achieve greater cost-effectiveness and impact. One major aim is to reduce gender disparity so that girls achieve a 95 per cent gross enrolment ratio, 60 per cent of girls complete five years of school and 50 per cent of girls also complete seven years of education. Other donor projects are addressing issues of quality and accessibility of primary education. UNICEF will complement these efforts by (a) supporting minimum basic education for out-of-school children; (b) mobilizing parental support for children's education, especially in rural areas; and (c) supporting early childhood development (ECD) and care initiatives for disadvantaged children.

44. Complementary opportunities for primary education will be provided for out-of-school children, with a special emphasis on girls. UNICEF will assist teachers recruited by both the community and the formal school system to provide classes at times and places convenient for out-of-school children. This should enable and encourage children to join the formal school system, while ensuring that they receive a basic minimum education if they are unable to do so. In this context, UNICEF will support advocacy for education as the right of every child. Communities will be mobilized to persuade parents to send every child to a primary school or out-of-school classes.

45. ECD activities can help to reduce socio-economic and gender-related inequalities in education. UNICEF will provide training and materials to support community-organized ECD activities that will focus on disadvantaged families and girls. Activities will include training of community-based, voluntary service workers and sensitizing policy makers and leaders to the needs of disadvantaged children. Members of 4,800 village committees will receive special training in management and monitoring. Resource persons will be selected by communities to receive special training in rural community participation and appraisal methods.

46. UNICEF assistance to address HIV/AIDS will continue to focus on safeguarding youth from AIDS, using both out-of-school and school-based approaches. As HIV/AIDS is not the only major social need of youth, UNICEF support for reducing HIV transmission will contribute in other ways to the achievement of UNPAC goals, for example, by reducing teenage pregnancies. Leaders will be trained and supported to strengthen capacity of communities to improve dialogue with parents and children to instill in children a sense of responsibility and concern for their own health, to help youth delay the age of first sexual intercourse and to promote safe sexual and other health-related behaviour among adolescents. Over 3,000 paralegals will be trained to support community leaders to deal with crimes of sexual abuse.

47. UNICEF will also assist the development of curricula for in-school and out-of-school education which will educate adolescents on reproductive health, life skills and children's rights. Adolescents will be encouraged and assisted to develop activities that promote healthy and safe sexual behaviour. Counselling services for families, children and adolescents will be promoted and strengthened both at schools and in the communities.

48. At the national level, the cooperation will provide material, logistical and technical support for policy makers and managers to formulate appropriate, gender-sensitive policies on HIV/AIDS for children and adolescents. The main participating organizations will be the Uganda AIDS Commission and the Ministries of Labour and Social Affairs, Women in Development, Youth and Culture, Health and Education, as well as NGOs and religious organizations. Technical assistance will be given to develop appropriate materials for different target groups. UNICEF will support the development of indicators and strengthen existing information management systems to monitor and evaluate activities that promote safe sexual behaviour among children and adolescents. Research on socio-cultural behaviour affecting reproductive health and the transmission of sexually transmitted diseases will be supported and strengthened to provide more accurate information for developing well-targeted IEC interventions.

49. Child care and protection will be linked to implementation of the Convention on the Rights of the Child and the Convention for the Elimination of All Forms of Discrimination Against Women. Capacity-building will include training ministry and NGO staff to identify and support community-based initiatives and improve care for the most deprived children including orphans, street children and children with disabilities. The unmet needs of girls will be a priority. The programme will also support mechanisms for collaboration among NGOs and government agencies. Over 1,000 district-level resource persons will be sensitized in the first year of implementation. UNICEF will also support the establishment and strengthening of research capacity and monitoring systems, including community-based information systems. This will be achieved through the training of 4,800 Resistance Council vice-chairpersons responsible for children's affairs. The main partners will be the Ministry of Labour and Social Affairs and the Uganda Community-Based Association for Child Welfare.

Coordination, communication and advocacy

50. Common processes, such as gender analysis or social mobilization, were not sufficiently addressed or integrated into previous country programmes of cooperation. The new country programme will emphasize sustainability through the mobilization and management of available resources. As a result, the roles of managers, decision makers and opinion leaders such as elected officials and administrators, who will deal with the entirety of the cooperation, will become increasingly important. The coordination, communication and advocacy programme will involve these many influential persons who do not belong to a specific sectoral programme. This cross-sectoral programme will help these key personnel to coordinate and support the sectoral programmes and activities for promoting the well-being of women and children. The target will be the development and monitoring of 39 district plans of action for children by 1997, 800 sub-county plans by 1999 and the development of community-based management information systems in 4,800 parishes by 2000.

51. The programme will provide material, financial, logistical and technical support to strengthen women's participation in decision-making and resource management and upgrade the skills of sectoral and cross-sectoral managers in gender analysis. Five other cross-cutting skills will also be promoted: information management; the use of nutritional status as an indicator of programme performance; resource mobilization and management; environmental analysis; and communication. UNICEF will also assist in the development and

strengthening of mechanisms for improved coordination between sectoral programmes and the pooling of resources for complementary programme activities such as social mobilization to minimize duplication and promote efficiency and cost-effectiveness.

52. The programme will provide training and guidelines to strengthen the skills of 5,300 district- and lower-level managers to help them better exercise the authority being devolved to them through the decentralization process. UNICEF will also support management processes such as assessments, which result in more informed, coordinated and rational actions for the improvement of the well-being of women, children and adolescents.

53. The development of the overall communication strategy and associated materials will take place at the national level. This will include advocacy, programme communication and social mobilization based on research and targeted at behaviour change. The programme will also support mechanisms at the national level for coordinating the country programme within the framework of national policies and plans. Unresolved policy issues will be addressed, including among others, safe motherhood and family planning, the status of education received out-of-school and further clarification on decentralization. The main partners at the national level will be the Ministries of Finance and Economic Planning, Local Government, Women in Development, Youth and Culture, as well as the National Resistance Movement Secretariat and NCC.

Cooperation with other partners

54. A wide range of technical ministries and NGOs have been involved in previous programme cooperation. The Ministry of Local Government and the districts will be major new partners. There will be close collaboration with programmes assisted by other donor agencies. At the policy level, technical advisers and staff of related donor-assisted programmes will be asked to participate in all policy development, activity design and associated development of IEC materials. Each programme has been designed to complement and reinforce other donor-assisted programmes. In most cases there is an inter-dependency, such as with the essential drugs programme supported by the Danish International Development Agency (DANIDA) as part of the essential health service package, the DANIDA-supported rural water supply and sanitation programme in nine districts not covered by UNICEF, and the World Bank and United States Agency for International Development education programmes which focus on quality and accessibility of the formal school system. Government-UNICEF cooperation will encourage other donors to follow a similar approach in the districts which they support, so as to promote more rapid implementation. UNICEF will also participate in the preparation of a country strategy note with the Government and other United Nations agencies which would become effective during the programme period.

Monitoring and evaluation

55. An integrated monitoring and evaluation plan will support the processes of decision-making and provide timely and reliable information on progress towards the UNPAC goals. Research, monitoring and evaluation activities will guide managers in each programme to improve cost-effectiveness and to analyse progress in terms of coverage, access, utilization, impact and gender equity. Annual and mid-term reviews will provide an opportunity to bring together and analyse information from routine information systems, community sentinel sites, surveys, routine monitoring and supervision and external evaluations.

56. The programme will strengthen existing information systems rather than develop new ones. Local capacity will be strengthened to manage information systems, especially nationwide community surveillance sites, to complement routine information systems. Special attention will be given to evaluating

behavioural changes. A baseline knowledge and practice survey of communities is planned for the first year, and repeat surveys will occur in subsequent years. Costs relative to behavioural change will also be monitored closely.

Programme support and management

57. Existing government and non-government organizations will implement all programmes. To strengthen links between sectors, a multisectoral committee representing participating ministries and other institutions will oversee each programme. The committee for the coordination, communication and advocacy programme will be responsible for the overall coordination of the country programme. At the national level, annual programme plans of action will detail the implementation of activities and assign responsibility for them. At the district level, implementation will be guided by letters of understanding describing the management framework, operating procedures and allocation of responsibilities. Sectoral subcommittees of district Resistance Councils will detail programme activities in district sectoral plans and budgets. The councils themselves must ultimately approve the plans. Relevant ministries will review the proposal plans for consistency with national policies, guidelines and priorities, especially those related to UNPAC.

58. The government policy on decentralization and the resulting shift from vertical sectoral programmes to district planning, management and coordination of basic services has important implications for UNICEF programme management. One UNICEF officer will be assigned to one of four groups of districts as the principal liaison officer for support to all country programme activities. This officer will liaise between the districts and the UNICEF Kampala office and follow through on the activities of the country programme in the district. To complement this approach, the other professional staff, in addition to their responsibilities for sectoral programmes, will be responsible for following up implementation of their sectoral programmes and the country programme as a whole within a group of districts. With this adjustment the UNICEF staff complement will be reduced by 11 posts to a total of 75.

59. The strategy for fund-raising is to sustain the support of existing donors, to attract new donors and to develop innovative funding relationships with lending institutions and the private sector. The emphasis on capacity-building for decentralization of domestic resources should attract donors with interests in improved sustainability of basic services.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Uganda	(1992 and earlier years)		UNICEF country classification
Under-five mortality rate	185	(1993)	Very high U5MR
Infant mortality rate	111	(1993)	Very high IMR
GNP per capita	$ 170	(1992)	Low-income GNP
Total population	19.3 million	(1993)	

KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1990	1993
Births	(thousands)	483	643	901	983
Infant deaths (under 1)	(thousands)	54	70	100	109
Under-five deaths	(thousands)	90	116	167	182
Under-five mortality rate (per 1,000 live births)		186	181	185	185
Infant mortality rate (under 1) (per 1,000 live births)		112	109	111	111

		About 1980	Most recent
Underweight children (under 5) (% weight for age, 1989)	Moderate & severe	..	23 *
	Severe	..	10 *
Babies with low birth weight (%)		..	..
Primary school children reaching grade 5 (%, 1980)		79	..

NUTRITION INDICATORS	About 1980	Most recent
Exclusive breast-feeding rate (<4 mos.) (%, 1989)	..	70
Timely complementary feeding rate (6-9 mos.) (%, 1989)	..	67
Continued breast-feeding rate (20-23 mos.) (%, 1989)	..	39
Prevalence of wasting (0-59 mos.) (%, 1989)	..	2 *
Prevalence of stunting (0-59 mos.) (%, 1989)	..	45 *
Daily per capita calorie supply (% of requirements, 1979-1981/1988-1990)	92	93
Total goitre rate (1991)	..	7
Household expenditure (% of total income)	All food/cereals ..	.. / ..

HEALTH INDICATORS		About 1980	Most recent
ORT use rate (%, 1986/1993)		5	45
Access to health services	Total	61	49
(% of population, 1980/1992)	Urban/rural	90 / 57	99 / 42
Access to safe water	Total	20	31
(% of population, 1985/1992)	Urban/rural	37 / 18	58 / 28
Access to adequate sanitation	Total	30	57
(% of population, 1985/1992)	Urban/rural	32 / 30	94 / 52
Births attended by trained personnel (%, 1989)			38
Maternal mortality rate (per 100,000 live births, 1992)		..	550

Immunization		1981	1985	1990	1993
One-year-olds (%) immunized against:	Tuberculosis	18	37	99	99
	DPT	9	14	77	73
	Polio	8	13	77	74
	Measles	22	17	74	73
Pregnant women (%) immunized against:	Tetanus	20	20	31	83

* Aged 0-60 months.

TABLE 1 (continued)

Uganda

EDUCATION INDICATORS		About 1980	Most recent
Primary enrolment ratio (gross/net) (%, 1980/1988)	Total	50 / ..	80 / ..
	Male	56 / ..	.. / ..
	Female	43 / ..	.. / ..
Secondary enrolment ratio (gross/net) (%, 1980/1988)	Total	5 / ..	14 / ..
	Male	7 / ..	.. / ..
	Female	3 / ..	.. / ..
Adult literacy rate, 15 years & older (%, 1985/1990)	Total	43	48
	Male/female	57 / 29	62 / 35
Radio/television sets (per 1,000 population, 1980/1991)		30 / 6	109 / 10

DEMOGRAPHIC INDICATORS		1970	1980	1990	1993	2000
Total population	(thousands)	9806	13120	17560	19246	23401
Population aged 0-15 years	(thousands)	4828	6567	8880	9783	12022
Population aged 0-4 years	(thousands)	1914	2597	3512	3908	4537
Urban population (% of total)		8.0	8.8	11.2	12.1	14.2
Life expectancy at birth (years)	Total	46	47	43	42	42
	Male	45	45	42	41	41
	Female	48	49	44	43	43
Total fertility rate		6.9	7.0	7.3	7.2	6.4
Crude birth rate (per 1,000 population)		50	49	51	51	47
Crude death rate (per 1,000 population)		19	18	20	21	20

		About 1980	Most recent
Contraceptive prevalence rate (%, 1989)		..	5.0
Population annual growth rate (%, 1965-1980/1980-1993)	Total	3.3	2.9
	Urban	5.3	5.4

ECONOMIC INDICATORS		About 1980	Most recent
GNP per capita annual growth rate (%, 1965-1980/1980-1992)		-2.2	3.3
Inflation rate (%, 1980-1992)		..	107
Population in absolute poverty (%)	Urban/rural	.. / ..	.. / ..
Household income share (%, 1990)	Top 20%/bottom 40%	.. / ..	42 / 21
Government expenditure (% of total expenditure, 1980/1986)	Health/education	3 / 15	2 / 15
	Defence	25	26
Household expenditure (% share of total, 1980 or 1985)	Health/education	.. / ..	.. / ..
Official development assistance: (1981/1992)	$US millions	136	718
	As % of GNP	..	24
Debt service (% of goods and services exports, 1982/1992)		12	22

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1990-1994 a/

COUNTRY: UGANDA
LATEST BOARD APPROVAL: 1990
GENERAL RESOURCES: $28 002 101

(In thousands of United States dollars)

Programme sectors/areas	Supplies and equipment (actual)		Training grants (actual)		Project staff (actual)		Other cash (actual)		TOTAL					
									General resources		SF		Total (GR & SF)	
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Actual	Planned	Actual	Planned	Actual	Planned
Health	3 403	7 520	819	1 023	796	3 716	3 100	4 541	8 118	13 391	16 800	36 770	24 918	50 161
Water supply and sanitation	1 839	13 613	297	366	270	3 689	898	3 095	3 304	6 538	20 763	26 098	24 067	32 636
Education	370	948	185	218		239		239	555	621	1 644	4 687	2 199	5 308
Community organization and development	1 194	2 077	343	812	15	1 159	1 292	3 232	2 844		7 280	13 690	10 124	13 690
Women-centred programme										650		2 450		3 100
Social mobilization and advocacy										1 400		2 822		4 222
Planning and social statistics	54				5				59	347			59	347
Programme support	1 277	79	416	1	3 689	140	2 561	83	7 943	5 055	303		8 246	5 055
GRAND TOTAL	8 137	24 237	2 060	2 420	4 775	8 943	7 851	11 190	22 823 b/	28 002 c/	46 790	86 517 d/	69 613	114 519

GR = General resources.
FSF = Programmes approved for funded supplementary funding.
SF = Programmes for supplementary funding, funded and unfunded.

a/ Actual expenditures include expenditures recorded as of November 1994.
b/ Including expenditures from global fund and additional allocation of general resources for unfunded programmes for supplementary funding.
c/ Including additional general resources of $5 202 101 (E/ICEF/1994/P/L.30).
d/ Of this amount, $49 547 800 remains unfunded.

TABLE 3. PLANNED EXPENDITURE, 1995 - 2000

(In thousands of United States dollars)

Country: UGANDA **Period covered: 1995 - 2000**	**Funding status**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**Total**
Health	GR	1 200	1 280	1 380	1 380	1 380	1 380	8 000
	FSF	2 650	440					3 090
	NSF	2 350	4 560	4 600	4 600	3 800	3 400	23 310
Water supply and environmental sanitation	GR	1 000	1 080	1 080	1 080	1 080	1 080	6 400
	FSF	2 407						2 407
	NSF	1 093	3 500	3 500	3 500	3 500	3 500	18 593
Basic education, child care and adolescent development	GR	1 000	1 100	1 100	1 100	1 100	1 100	6 500
	NSF	3 000	3 000	3 300	3 300	4 000	4 400	21 000
Coordination, communication and advocacy	GR	800	860	760	760	760	760	4 700
	NSF	1 000	1 100	1 250	1 300	1 400	1 450	7 500
Programme support	GR	1 100	1 180	1 180	1 180	1 180	1 180	7 000
	NSF	250	250	250	250	250	250	1 500
TOTAL	GR	5 100	5 500	5 500	5 500	5 500	5 500	32 600
	FSF	5 057	440					5 497
	NSF	7 693	12 410	12 900	12 950	12 950	13 000	71 903
GRAND TOTAL		17 850	18 350	18 400	18 450	18 450	18 500	110 000

GR = General resources.
FSF = Programmes approved for funded supplementary funding.
NSF = New programmes for supplementary funding.